

Prescription Form

Fax To: 1-866-553-6400

Patient Name	Phone	D.O.B.	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address		Date of Exam	

✓	Check <u>ALL</u> That Apply...
---	---------------------------------------

- 1. The patient's pain persists beyond the anticipated time of tissue healing (i.e. chronic pain)
- 2. The patient demonstrates physiological impairment, or dysfunction, that prevents either their return to work, attaining full-duty pre-injury status, or reaching maximum medical improvement
- 3. The patient is a medically stable non-surgical candidate who has exhausted all other treatment options without achieving full functional recovery
- 4. The claimant is exhibiting psychological reactions to pain (i.e. fear of pain, avoidance behaviors, depression, increased pain behaviors, etc.) that interfere with functional recovery
- 5. The claimant is exhibiting dysfunctional movement patterns such as antalgic gait, abnormal postures or muscle guarding that is contributing to pain chronicity
- 6. The claimant is exhibiting motivational, affective, cognitive or behavioral overlays that are compounding recovery efforts
- 7. The patient is approaching ratability with significant permanent disability expected
- 8. The patient's symptoms and medication usage have not decreased appropriately over time
- 9. The patient's pain distribution is non-anatomic or described in a bizarre or atypical manner
- 10. The patient exhibits significant de-conditioning that heightens disability
- 11. The patient over-estimates the amount of pain during functional activities causing activity avoidance
- 12. Other: _____

Rx

The MMI-Izer™ Functional Restoration Program [BioFunction®]

- Evidentiary Forensic Disability Examination [Baseline Exam Only]
- Forensic Myotonometry Examination
- Full MMI-zer™ Program [Baseline Exam + Functional Restoration Module(s)]

Functional Restoration Modules [select appropriate module(s)]:

- | | |
|--|--|
| <input type="checkbox"/> Neck & Shoulder | <input type="checkbox"/> Upper Arm & Elbow |
| <input type="checkbox"/> Upper Torso | <input type="checkbox"/> Wrist, Hand & Forearm |
| <input type="checkbox"/> Lower Torso | <input type="checkbox"/> Leg, Ankle & Foot |

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and I have not violated Labor Code § 139.3.

Physician Signature

Cal. Lic #

Phone | _____
Fax

Specialty

For BioFunction® Use Only	Certification Sent:	<input type="checkbox"/> Approved	<input type="checkbox"/> Appeal
		<input type="checkbox"/> Denied	<input type="checkbox"/> Peer-To-Peer